BHSF Form 2-L (WP)
Rev. 12/07
Prior Issue Obsolete

Medicaid Renewal Form
for HCBS Waivers and PACE

Renewal Month: _____

CSLD/WKR: _____

Return this form or call us by:

Use this form to renew Medicaid coverage for the person in the Waiver or PACE program. If you do not renew, medical coverage will end. You may renew by mail, phone, fax, or in person. After we hear from you, we will let you know if they still qualify.

How to Renew

By mail: Fill out and sign this form. Return the form and needed documents (see page 6) in the envelope provided. If you need extra space on any question, use a separate sheet of paper.
By phone: Call the worker who sent you this form. You may also call (toll-free) 1-888-342-6207 Monday through Friday 8:00 A.M. to 4:00 P.M. Press 1 for English and then 0 for an operator who will transfer you to your worker. You must speak to your worker to renew by phone. If you are deaf or hard of hearing and have a TTY text telephone, call 1-800-220-5404.
By fax: Fill out and sign this form. Fax it and needed documents (see page 6) to the fax number on the letter that came with this form. If you need extra space on any question, use a separate sheet of paper.
In person: Visit your closest Medicaid office. The address to your local Medicaid office is on the letter that came with this form.

START HERE – Please use a black ink pen.

What language do you speak best? ☐ *English* ☐ *Spanish* ☐ *Vietnamese* ☐ *Other (specify)* _____
What language do you write best? ☐ *English* ☐ *Spanish* ☐ *Vietnamese* ☐ *Other (specify)* _____

1. Person Getting Medicaid

Name _____ Date of Birth _____
First *Middle Initial* *Last*
Social Security Number _____ Medicare Claim Number _____
Home Address _____ Apt/Lot _____
City _____ State _____ Zip _____ Parish _____
Mailing Address (if different) _____ Apt/Lot _____
City _____ State _____ Zip _____
Daytime Phone Number (_____) _____ Cell Phone Number (_____) _____
E-mail Address _____
Best Day and/or Time for Us to Call You During Our Office Hours (8:00am-4:30pm, Monday - Friday) _____
_____

2. Who takes care of this person's business affairs? ❑ They Do – Go to Question 3 ❑ I Do – Fill Out Below

Your Name _____
Mailing Address _____ Apt/Lot _____
City _____ State _____ Zip _____

Questions - Call 1-888-342-6207
(TTY text telephone for deaf and hard of hearing: 1-800-220-5404)

Daytime Phone Number (_____) _____ Cell Phone Number (_____) _____

E-mail Address _____

Best Day and/or Time for Us to Call You During Our Office Hours (8:00am-4:30pm, Monday - Friday) ____

_____

Do you have Power of Attorney? ❑ Yes ❑ No Are you the Curator or Under Curator? ❑ Yes ❑ No

3. Give us information about this person's health insurance, Long Term Care Insurance, Medicare supplement, or Medicare prescription plan. ❑ No Insurance – Go to Question 4
If more than 2, use another sheet of paper.

Policy #1

Insurance Company Name _____ Monthly Premium Cost _____

Policy Number _____ Group Number _____

Policy #2

Insurance Company Name _____ Monthly Premium Cost _____

Policy Number _____ Group Number _____

4. Do they have a spouse living with them? ❑ Yes – Fill Out Below ❑ No – Go to Question 5

Spouse's Name _____
First *Middle Initial* *Last*

5. INCOME: Give us information about the income of the person getting Medicaid.

What is it?	**How often is it received?**	**Gross Amount Received** **$**
What is it?	**How often is it received?**	**Gross Amount Received** **$**
What is it?	**How often is it received?**	**Gross Amount Received** **$**

6. Has the person who gets Medicaid applied for income like Social Security or Veteran's Benefits, but did not get it, yet? ❑ Yes – Fill Out Below ❑ No – Go to Question 7

What is it? ❑ Social Security ❑ Veteran's Benefits ❑ Other _____

7. Has the person who gets Medicaid or their spouse received a lump sum of money such as from an insurance, lawsuit, or worker's comp settlement, inheritance, or a Social Security payment or are they expecting to receive a lump sum? ❑ Yes – Fill Out Below ❑ No – Go to Question 8

Who? ❑ Person Getting Medicaid ❑ Spouse

Amount $_____ When? _____ From what? _____

For what reason? _____

Attorney's Name, Address, and Phone Number_____

_____

8. ASSETS / RESOURCES: Fill out the spaces below about the assets of the person who gets Medicaid and their spouse. (Let us know if they still have these and about new things)**.**

ASSET TYPE	Still Have It	No Longer Have It	New
Tell us if the person getting Medicaid or their spouse has this item.	**Answer each question below.**	**For each type, answer: What happened to it?** **When did you or they get rid of it?**	**For each type, answer: When did you or they get it? How much is it worth? Name of bank or company.**
Life Insurance, Burial Insurance: ❑ Never had it ❑ No longer have it ❑ Still have it ❑ New: Got it in past year	**How much?**		
Bank Account for Burial, Pre-arranged Burial Contract with Funeral Home: ❑ Never had it ❑ No longer have it ❑ Still have it ❑ New: Got it in past year	**How much is in the account/contract?**		
Checking/Savings/Christmas Club Accounts: ❑ Never had it ❑ No longer have it ❑ Still have it ❑ New: Got it in past year	**How much is in the account(s)?**		
Certificates of Deposit (CDs): ❑ Never had it ❑ No longer have it ❑ Still have it ❑ New: Got it in past year	**How much is it worth?**		
Cash on Hand or Held by Someone Else: ❑ Never had it ❑ No longer have it ❑ Still have it ❑ New: Got it in past year	**How much?**		**How much? Where did the cash come from?**
Annuities, Trusts: ❑ Never had it ❑ No longer have it ❑ Still have it ❑ New: Got it in past year	**How much is in the account(s)?**		
Stocks, Bonds: ❑ Never had it ❑ No longer have it ❑ Still have it ❑ New: Got it in past year	**How much is it worth?**		

ASSET TYPE	Still Have It	No Longer Have It	New
Tell us if the person getting Medicaid or their spouse has this item.	**Answer each question below.**	**For each type, answer:** **What happened to it?** **When did you or they get rid of it?**	**For each type, answer:** **When did you or they get it?** **How much is it worth?** **Name of bank or company.**
Retirement Accounts: ❑ Never had it ❑ No longer have it ❑ Still have it ❑ New: Got it in past year	**How much is in the account(s)?**		
Safe-Deposit Box: ❑ Never had it ❑ No longer have it ❑ Still have it ❑ New: Got it in past year	**What is inside?**		**What is inside?**
Land, Second Home (not home property): ❑ Never had it ❑ No longer have it ❑ Still have it ❑ New: Got it in past year	**How much is it worth?**		
Car, Truck, Camper, Boat, ATV, Motorcycle: ❑ Never had it ❑ No longer have it ❑ Still have it ❑ New: Got it in past year	**How much is it worth?**		
Other _____: ❑ No longer have it ❑ Still have it ❑ New: Got it in past year	**How much is it worth?**		

9. Give us more information about annuities belonging to the person getting Medicaid and their spouse. ❑ No Annuities – Go to Question 10 ***If more than 2, use another sheet of paper.***

Annuity #1

Date Purchased _____ Beneficiary _____ Remainder Beneficiary _____

Annuity #2

Date Purchased _____ Beneficiary _____ Remainder Beneficiary _____

10. Does the person who gets Medicaid own or co-own a home? ❑ Yes – Fill Out Below ❑ No – Sign Form on the Next Page

List all owners. _____
How much is it worth? _____ How much is owed on it? _____
Give us information about it like the location, lot size or number of acres, and if there are buildings on it.

_____
Does anyone live in the home? ❑ Yes – Fill Out Below ❑ No – Sign Form on the Next Page
What is their relationship to the person who gets Medicaid? ❑ Spouse ❑ Child ❑ Parent
❑ Brother/Sister ❑ Someone else (give name) _____
Is this person paying rent to live there? ❑ Yes ❑ No How much is paid every month? $_____

This is the end of the form. You must sign the form on the next page.

YOUR RIGHTS AND RESPONSIBILITIES

WHAT MEDICAID HAS THE RIGHT TO EXPECT OF YOU (the person getting Medicaid)

REPORTING THE TRUTH: You state that the information you give on this renewal form is true and correct. You understand if you purposely give information that is not true or if you purposely do not tell information that you are supposed to, you may get health benefits that you should not get. If that happens, you can by law be punished for fraud. Also, you may have to pay money back to Medicaid for the bills it paid by mistake.

VERIFICATION OF INFORMATION: You understand that the information you give will be checked. You agree to help with this and let Medicaid get information it needs from government agencies, employers, medical providers, etc.

SOCIAL SECURITY NUMBERS: You understand Social Security numbers will only be used to get information from other government agencies to make a decision about your eligibility for Medicaid.

PAYMENT OF MEDICAL CARE BY A THIRD PARTY: You understand by accepting Medicaid, the Department has the right to money you get from other sources like insurance payments or lawsuit settlements for services that Medicaid has paid for you.

REPORTING CHANGES: You agree to tell Medicaid within 10 days of these changes: 1) if you move out of state; 2) changes in mailing or home address; 3) if anyone moves in or out of your home; 4) changes in health insurance and premiums; 5) changes in income; and 6) changes in things you own.

CHILD SUPPORT ENFORCEMENT: You understand that Medicaid will only send information to Child Support Enforcement for medical support if you ask them to.

ANNUITIES: You agree that by accepting Medicaid, the State of Louisiana will be named as the remainder beneficiary at your death for the total amount of medical assistance paid on your behalf for all annuities purchased on or after Feb. 8, 2006, unless you have a spouse, minor child, or a child with a disability. In these cases, the State must be named as beneficiary after these individuals. You agree to tell Medicaid about any annuity you and your spouse own or co-own regardless if the annuity is irrevocable (cannot be changed) or Medicaid counts it. You understand that you must tell Medicaid about changes made to any annuity which may affect the amount paid, frequency of payments, when payments begin, and additions to the principal.

WHAT YOU (the person getting Medicaid) HAVE THE RIGHT TO EXPECT FROM MEDICAID

RIGHT TO A FAIR HEARING: You understand that you can ask for a Fair Hearing if you think any decision made on your case is unfair, incorrect, or made too late.

NO DISCRIMINATION: You understand Medicaid cannot treat you differently because of race, color, sex, age, disability, religion, nationality, or political belief. If you think it has, you can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 4818 Baton Rouge, LA 70821-4818.

OTHER SERVICES: You understand Medicaid will send you information about WIC, KIDMED, and other Medicaid services.

ESTATE RECOVERY: You understand that Estate Recovery rules require the Department to recover the cost of certain Medicaid payments from your estate. These costs include the total amount of payments for facility services, hospital care, payments to HCBS or PACE providers, and prescription drugs received at age 55 or older. The estate is the property owned at the time of death. The Department will not make a claim against the estate while you or your legal spouse is still living or if you have a dependent child who is under age 21, blind, or disabled. Collection may not be made if it is not cost effective for the Department to do so, or if your heirs apply for a hardship waiver after your death. A hardship may exist if the estate property is the only source of income for the heirs, if that income is limited, or other convincing situations.

⬇ SIGN BELOW ⬇

Sign Here:_____ **Date** _____

If signed with an "X", two witnesses must sign.

_____ **Date**_____ _____ **Date**_____

*If Medicaid filled out this form, they will sign here.*_____ **Date** _____

See next page for a list of documents you may need to send us.

Documents of Proof We May Need From You

If someone from Medicaid interviewed you, then…

Please send the documents of proof marked with a check ✓ to the Medicaid office at:

_____by _____.

You may keep this page.

If you filled out the renewal form, then…

Keep in mind **not** everything will apply. To help you decide what to send, enter a check ✓ next to each document of proof you think does apply. *You may keep this page*.

Let us know if you do not have or cannot get any of these documents of proof, because we may be able to get them or help you get them. Please trust that the information you give us on this form and everything you send us will be kept confidential. We are required by law to keep it private.

✓	What to send:	See Question
	Proof of health insurance premium amount.	**3**
	Proof of income such as the 1099 from the last tax year, a check stub, or award letter showing amount of gross income (before withholdings) from retirement, pension, a job, Veteran's Benefits, annuities, mineral rights, worker's comp, child support, reverse annuity mortgages, and royalties.	**5**
	Proof of any lump sum payments received in the last year from an insurance or lawsuit settlement, inheritance, worker's comp settlement, or Social Security.	**7**
	Proof of ownership and value for any new assets/resources.	**8**
	If the person getting Medicaid has a home and they rent it to someone, send proof of the amount of rental income received (letter from renters or cancelled check) and proof of the expenses of the rental property.	**10**
	Other:	
	Other:	